		FOR BHF USE					

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0011288

Facility Name: Marklund Children's Home

Address: 164 South Prairie Avenue (Number) Bloomingdale (City) 60108 (Zip Code)

County: DuPage

Telephone Number: (630) 593-5479 **Fax #** (630) 593-5481

HFS ID Number: 36-2652532001

Date of Initial License for Current Owners: 10/01/68

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
x	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501 (c) 3		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Lisa Custardo **Telephone Number:** (630) 593-5479

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/04 to 06/30/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Lisa L. Custardo
(Title) Executive Director

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/04 Ending: 06/30/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2	30	Skilled Pediatric (SNF/PED)	30	10,950	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	30	TOTALS	30	10,950	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED	10,108	364	7	10,479	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,108	364	7	10,479	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.70%

D. How many bed-hold days during this year were paid by the Department?
236 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 10/01/68

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/05 Fiscal Year: 06/30/05

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Marklund Children's Home # 0011288 **Report Period Beginning:** 07/01/04 **Ending:** 06/30/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	99,975	5,271	8,878	114,124		114,124		114,124			1
2	Food Purchase		80,333		80,333		80,333		80,333			2
3	Housekeeping	65,582	15,801		81,383		81,383		81,383			3
4	Laundry	38,320	10,070		48,390		48,390		48,390			4
5	Heat and Other Utilities			82,546	82,546		82,546		82,546			5
6	Maintenance	37,825	30,340	57,008	125,173		125,173		125,173			6
7	Other (specify):*			18,126	18,126		18,126		18,126			7
8	**TOTAL General Services**	241,702	141,815	166,558	550,075		550,075		550,075			8
	B. Health Care and Programs											
9	Medical Director			29,002	29,002		29,002		29,002			9
10	Nursing and Medical Records	1,293,516	159,312	319,608	1,772,436	(641,407)	1,131,029		1,131,029			10
10a	Therapy	51,416	475	20,835	72,726		72,726		72,726			10a
11	Activities	24,960	12,245	695	37,900		37,900		37,900			11
12	Social Services	9,880			9,880		9,880		9,880			12
13	CNA Training		87		87	55,927	56,014		56,014			13
14	Program Transportation	9,768			9,768		9,768		9,768			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,389,540	172,119	370,140	1,931,799	(585,480)	1,346,319		1,346,319			16
	C. General Administration											
17	Administrative	65,000			65,000		65,000		65,000			17
18	Directors Fees											18
19	Professional Services			24,119	24,119		24,119	(15,416)	8,703			19
20	Dues, Fees, Subscriptions & Promotions			60,525	60,525		60,525	(16,116)	44,409			20
21	Clerical & General Office Expenses	128,215	67,514	50,508	246,237	(8,766)	237,471		237,471			21
22	Employee Benefits & Payroll Taxes			337,766	337,766		337,766		337,766			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,385	5,385		5,385		5,385			24
25	Other Admin. Staff Transportation			13,248	13,248		13,248		13,248			25
26	Insurance-Prop.Liab.Malpractice			87,336	87,336		87,336		87,336			26
27	Other (specify):*			5,427	5,427		5,427	(5,427)				27
28	**TOTAL General Administration**	193,215	67,514	584,314	845,043	(8,766)	836,277	(36,959)	799,318			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,824,457	381,448	1,121,012	3,326,917	(594,246)	2,732,671	(36,959)	2,695,712			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Marklund Children's Home #0011288 **Report Period Beginning:** 07/01/04 **Ending:** 06/30/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			330,727	330,727		330,727	(21,956)	308,771			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,675	1,675		1,675	(1,675)				32
33	Real Estate Taxes			24	24		24	(24)				33
34	Rent-Facility & Grounds			41,177	41,177		41,177	(41,177)				34
35	Rent-Equipment & Vehicles					8,766	8,766		8,766			35
36	Other (specify):*											36
37	**TOTAL Ownership**			373,603	373,603	8,766	382,369	(64,832)	317,537			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					585,480	585,480		585,480			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			202,255	202,255		202,255		202,255			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			202,255	202,255	585,480	787,735		787,735			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,824,457	381,448	1,696,870	3,902,775		3,902,775	(101,791)	3,800,984			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/04 Ending: 06/30/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	1,675	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	16,116	20		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	15,416	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	2,500	27		24
25	Fund Raising, Advertising and Promotional	5,427	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	63,157			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 104,291		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 104,291		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Marklund Children's Home

ID# 0011288

Report Period Beginning: 07/01/04

Ending: 06/30/05

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	depreciation	$ 21,956	30	1
2	real estate taxes	24	33	2
3	rent	41,177	34	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	63,157		49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number Marklund Children's Home **#** 0011288 **Report Period Beginning:** 07/01/04 **Ending:** 06/30/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	15,416	0	0	0	0	0	0	0	0	0	0	15,416	19
20	Fees, Subscriptions & Promotions	16,116	0	0	0	0	0	0	0	0	0	0	16,116	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	7,927	0	0	0	0	0	0	0	0	0	0	7,927	27
28	**TOTAL General Administration**	39,459	0	0	0	0	0	0	0	0	0	0	39,459	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	39,459	0	0	0	0	0	0	0	0	0	0	39,459	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Marklund Children's Home** **# 0011288** **Report Period Beginning:** **07/01/04** **Ending:** **06/30/05**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	21,956	0	0	0	0	0	0	0	0	0	0	21,956	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	1,675	0	0	0	0	0	0	0	0	0	0	1,675	32
33	Real Estate Taxes	24	0	0	0	0	0	0	0	0	0	0	24	33
34	Rent-Facility & Grounds	41,177	0	0	0	0	0	0	0	0	0	0	41,177	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	64,832	0	0	0	0	0	0	0	0	0	0	64,832	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	104,291	0	0	0	0	0	0	0	0	0	0	104,291	45

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/04 Ending: 06/30/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V				$			$	$	1
2	V									2
3	V									3
4	V									4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$			$	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/04 Ending: 06/30/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION**

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/04 Ending: 06/30/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Direct Cost Budget	13,570,721	13,570,721	$ 251	$	3,374,056	$ 81	1
2	2	Food	Direct Cost Budget	13,570,721	13,570,721	200		3,374,056	64	2
3	3	Housekeeping	Direct Cost Budget	13,570,721	13,570,721	4,959		3,374,056	1,594	3
4	5	Utilities	Direct Cost Budget	13,570,721	13,570,721	43,811		3,374,056	14,081	4
5	6	Maintenance	Direct Cost Budget	13,570,721	13,570,721	20,979		3,374,056	6,743	5
6	7	Disposal	Direct Cost Budget	13,570,721	13,570,721	16,337		3,374,056	5,251	6
7	13	BNATP	Direct Cost Budget	13,570,721	13,570,721	271		3,374,056	87	7
8	14	Transportation	Direct Cost Budget	13,570,721	13,570,721	0		3,374,056	0	8
9	19	Professional Services	Direct Cost Budget	13,570,721	13,570,721	27,078		3,374,056	8,703	9
10	20	Fees, Subscription	Direct Cost Budget	13,570,721	13,570,721	131,150		3,374,056	42,152	10
11	21	Clerical/Office	Direct Cost Budget	13,570,721	13,570,721	592,204	407,000	3,374,056	155,505	11
12	22	Benefits	Direct Cost Budget	13,570,721	13,570,721	53,082		3,374,056	8,847	12
13	24	Travel & Seminars	Direct Cost Budget	13,570,721	13,570,721	9,791		3,374,056	3,147	13
14	25	Staff Transportation	Direct Cost Budget	13,570,721	13,570,721	17,902		3,374,056	5,754	14
15	26	Insurance	Direct Cost Budget	13,570,721	13,570,721	11,262		3,374,056	3,620	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 929,277	$ 407,000		$ 255,629	25

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/04 Ending: 06/30/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	N/A						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	N/A											6
7												7
8												8
9	**TOTAL Facility Related**						$	$			$	9
	B. Non-Facility Related*											
10	N/A											10
11												11
12												12
13												13
14	**TOTAL Non-Facility Related**						$	$			$	14
15	**TOTALS (line 9+line14)**						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Marklund Children's Home **#** 0011288 **Report Period Beginning:** 07/01/04 **Ending:** 06/30/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	N/A	8
	2001		9
	2002		10
	2003		11
	2004		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Marklund Children's Home COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0011288

CONTACT PERSON REGARDING THIS REPORT Lisa Custardo

TELEPHONE (630) 593-5500 FAX #: (630) 593-5481

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	02-14-301-031	Residential - Tax exempt	$ None	$ None
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/04 Ending: 06/30/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 27,216 B. General Construction Type: Exterior Brick Frame Cement/Cinder Block Number of Stories 2

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Patient Care	206,930	1968	$ 31,500	1
2					2
3	TOTALS	206,930		$ 31,500	3

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/04 Ending: 06/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	32		1968	1953	$ 68,500	$	33	$	$	$ 68,500	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Pavillon land impr			1989	6,485	327	20	327		5,356	9
10	Landscaping land impr			1990	1,080		10			1,080	10
11	Asphalt Paving Land impr			1991	7,112		5			7,112	11
12	Asphalt Seal & Strip Parking Lot land impr			1994	14,893		5			14,893	12
13	Asphalt Land impr			1996	800		5			800	13
14	Seal & Repair Driveway Land impr			1998	600		5			600	14
15	Parking Lot Concrete Asphalt land impr			1999	300	30	5	30		300	15
16	Parking Lot Concrete Asphalt land impr			1999	32,199	3,220	5	3,220		32,199	16
17	Removal of ramp & installation of new land impr			1999	2,100	210	5	210		2,100	17
18	Parking Lot Concrete Asphalt land impr			2000	300	30	5	30		300	18
19	Resurface Playground land impr			2000	7,750	1,550	5	1,550		6,975	19
20	Sealcoat & Striping of Parking lot land impr			2000	3,187	637	5	637		2,868	20
21	Safety Surfacing of Playground			2000	6,094	1,219	5	1,219		5,485	21
22	Landscaping of Playground land impr			2000	3,325	665	5	665		2,993	22
23	Improvements prior to 1996 fully depreciated				208,807		v			208,807	23
24	Building Construction Pod II			1973	615,786	17,009	40	17,009		505,210	24
25	Oxygen Work			1974	74,064	2,047	40	2,047		58,704	25
26	Oxygen Work			1975	5,000	135	40	135		3,851	26
27	Oxygen Work			1976	7,535	188	40	188		5,604	27
28	New Roof			1986	81,000	4,050	20	4,050		78,975	28
29	Lobby Addition			1984	108,605	5,030	25	5,030		96,029	29
30	Parents Room			1987	42,000	2,100	20	2,100		36,750	30
31	POD general renovations floors/walls			1992	22,173		10			22,173	31
32	Fire Alarm			1993	850		10			850	32
33	Oxygen System			1993	13,429		10			13,429	33
34	Carpeting			1995	2,984	149	10	149		2,984	34
35	Water Heaters			1995	8,916	445	10	445		8,916	35
36	Vinyl Tile Flooring - Dental Office			1995	644	64	10	64		611	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/04 Ending: 06/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Window shades dining room	2000	$ 605	$ 60	5	$ 60	$	$ 605	37
38	Lobby walls	2000	57	5	5	5		57	38
39	Awnings rear entrance	2000	2,023	202	5	202		2,023	39
40	lower level classroom renovations	2000	183	18	5	18		183	40
41	awning for O2 protection	2000	3,477	348	5	348		3,477	41
42	Lobby walls	2000	4,997	500	5	500		4,997	42
43	HVAC-dining room	2000	610	61	5	61		610	43
44	Dining room walls & wall coverings	2000	2,060	206	5	206		2,060	44
45	HVAC coil dining room	2000	1,590	159	5	159		1,590	45
46	fire doors lower level	2000	564	56	5	56		310	46
47	carpet flooring lower level	1999	5,855	585	5	585		5,855	47
48	lower level classroom renovation	1999	1,346	134	5	134		1,346	48
49	replacement windows	1999	538	54	5	54		538	49
50	Construction, engineering, architect, inspection	1999	49,390	4,939	10	4,939		27,165	50
51	fire sprinkler system	1999	72,843	2,914	25	2,914		16,026	51
52	interior design, handrails, corner pieces	1999	29,873	1,992	15	1,992		10,954	52
53	Demolition old lower level	1999	26,641	2,664	10	2,664		14,652	53
54	Chair rails	1999	8,160	816	5	816		8,160	54
55	Wall Carpet	1998	4,887		5			4,887	55
56	Painting lower level	1999	19,835	1,983	5	1,983		19,835	56
57	lower level construction walls	1999	101,713	10,171	10	10,171		55,942	57
58	cabinets	1999	46,002	3,067	15	3,067		16,868	58
59	Reg. & auto doors	1999	18,259	1,826	10	1,826		10,042	59
60	Equip relocation	1999	2,495	249	5	249		2,495	60
61	Electrical work lower level	1999	29,697	2,969	10	2,969		16,333	61
62	windows/shutters	1999	15,529	1,552	10	1,552		9,317	62
63	Floor/carpeting	1999	46,503	4,650	5	4,650		46,503	63
64	Signage Interior/Exterior	1999	3,899	390	10	390		2,145	64
65	Plumbing lower level	1999	21,177	1,059	20	1,059		5,824	65
66	ECU Awnings	1999	3,994	266	15	266		1,464	66
67	Paneling	1999	7,309	731	5	731		7,309	67
68	Security System,Elevator	1999	11,010	734	15	734		4,037	68
69	New door hardware	1999	197	19	10	19		108	69
70	TOTAL (lines 4 thru 69)		$ 1,889,836	$ 84,484		$ 84,484	$	$ 1,498,171	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/04 Ending: 06/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,889,836	$ 84,484		$ 84,484	$	$ 1,498,171	1
2	Fire alarm system upper level	1999	12,491	500	25	500		2,748	2
3	Water Heater	2001	767	153	5	153		690	3
4	Air Curtain	2001	764	153	5	153		688	4
5	Replacement Parts - Boiler	2001	5,290	1,058	5	1,058		4,761	5
6	Compressor Pump	2001	1,599	320	5	320		1,440	6
7	Security Door	2001	2,427	485	5	485		2,184	7
8	New Flooring	2000	2,955	296	5	296		2,955	8
9	Roof Repair	1999	8,800		5			8,800	9
10	New compressor	1999	2,580	172	15	172		1,118	10
11	Awnings	1999	2,520		5			2,520	11
12	Boiler	1998	2,675		5			2,675	12
13	Plexiglass-reception area	2002	3,100	620	5	620		2,170	13
14	Stairwell Door replacements	2001	1,165	233	5	233		816	14
15	New Radiator for generator	2001	3,002	600	5	600		2,101	15
16	Sliding door repair	2002	4,179	836	5	836		2,090	16
17	Carpeting	2002	1,690	338	5	338		845	17
18	Awning	2002	2,694	538	5	538		1,347	18
19	Concrete Pads for Oxygen, Chiller, and Garbage	2002	15,571	3,114	5	3,114		7,785	19
20	Renovations: Architect, Engineering, reconstruct	2005	2,571,858	128,593	10	128,593	(0)	128,593	20
21	Renovations: Electrical work	2005	65,707	3,285	10	3,285		3,285	21
22	Renovations: Piping and Plumbing	2005	114,194	5,710	10	5,710		5,710	22
23	Renovations: Shelving	2005	1,118	56	10	56		56	23
24	Hot Water Heater	2005	4,529	453	5	453		453	24
25	Landscaping: plants, flowers, bushes	2005	4,055	406	5	406		406	25
26	Outdoor lighting, fencing, landscaping	2005	38,190	1,910	10	1,910		1,910	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,763,756	$ 234,312		$ 234,312	$ (0)	$ 1,686,316	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/04 Ending: 06/30/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 460,828	$ 44,941	$ 44,941	$		$ 424,710	71
72	Current Year Purchases	129,166	10,760	10,760			10,760	72
73	Fully Depreciated Assets	632,264					632,264	73
74								74
75	TOTALS	$ 1,222,258	$ 55,701	$ 55,701	$		$ 1,067,734	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transport	2000 International Bus	2000	$ 62,500	$ 6,250	$ 6,250	$	5	$ 62,500	76
77	Maintenance use	Isuzu Truck	2004	34,940	8,735	8,735		5	13,102	77
78	General/Laundry use	Ford E250	2000	18,867	3,773	3,773		5	16,980	78
79										79
80	TOTALS			$ 116,307	$ 18,758	$ 18,758	$		$ 92,582	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,133,821	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 308,771	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 308,771	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (0)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,846,632	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/04 Ending: 06/30/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ 8,766 Description: Office Equipment/Machinery
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/04 Ending: 06/30/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER CNA 82.5

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER CNA 44

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies		156	194		350
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)	24,701	30,876		55,577
6	Transportation					
7	Contractual Payments					
8	CNA Competency Tests					
9	TOTALS		$ 24,857	$ 31,070	$	$ 55,927
10	SUM OF line 9, col. 1 and 2	(e)	$ 55,927			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	5
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	4
2. From other facilities (f)	
TOTAL TRAINED	9

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program		26280	487,027			98,453	26,280	585,480	12
13	Other (specify):									13
14	TOTAL			$ 487,027		$	$ 98,453	26,280	$ 585,480	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Marklund Children's Home **#** 0011288 **Report Period Beginning:** 07/01/04 **Ending:** 06/30/05

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 06/30/05 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,157,619	$ 1,157,619	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 114,000)	2,529,348	2,529,348	3
4	Supply Inventory (priced at Cost)	40,240	40,240	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	59,187	59,187	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Client Related Accounts	601,779	601,779	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,388,173	$ 4,388,173	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	6,168,624	6,168,624	13
14	Buildings, at Historical Cost	20,049,202	20,049,202	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	4,576,555	4,576,555	16
17	Accumulated Depreciation (book methods)	(9,210,455)	(9,210,455)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	7,083,881	7,083,881	21
22	Other Long-Term Assets (specify):	2,063,846	2,063,846	22
23	Other(specify): Construction in Progress	746,266	746,266	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 31,477,919	$ 31,477,919	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 35,866,092	$ 35,866,092	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 200,301	$ 200,301	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	268,834	268,834	30
31	Accrued Taxes Payable (excluding real estate taxes)	21,507	21,507	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other-compensation and related payables	1,235,556	1,235,556	36
37	Misc. Other	2,688,761	2,688,761	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,414,959	$ 4,414,959	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,414,959	$ 4,414,959	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 31,451,133	$ 31,451,133	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 35,866,092	$ 35,866,092	48

***(See instructions.)**

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/04 Ending: 06/30/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 31,328,701	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 31,328,701	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	231,876	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	1,202,120	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Remaining Consolidated Inc/(loss)**	(1,545,315)	15
16	Other (describe) **Change in Unrealized Gains/(losses)**	303,450	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 192,131	17
	B. Transfers (Itemize):		
18	**Transfer out of Restricted Funds into Operations-Exp**	(69,699)	18
19	**Transfer out of Restricted Funds into Operations-Capital**	(987,530)	19
20	**Transfer into Operations from Restricted Funds-Capital**	987,530	20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (69,699)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 31,451,133	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/04 Ending: 06/30/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,534,539	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,534,539	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	7,545	5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 7,545	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	38	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	7,800	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 7,838	23
	D. Non-Operating Revenue		
24	Contributions	1,482,938	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,482,938	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,032,860	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	550,075	31
32	Health Care	1,346,319	32
33	General Administration	799,318	33
	B. Capital Expense		
34	Ownership	317,537	34
	C. Ancillary Expense		
35	Special Cost Centers	585,480	35
36	Provider Participation Fee	202,255	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,800,984	40
41	**Income before Income Taxes (line 30 minus line 40)****	231,876	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 231,876	43

*** This must agree with page 4, line 45, column 4.**

**** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

***** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/04 Ending: 06/30/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,976	2,080	$ 57,013	$ 27.41	1
2	Assistant Director of Nursing	0				2
3	Registered Nurses	18,673	19,656	531,114	27.02	3
4	Licensed Practical Nurses	0				4
5	CNAs & Orderlies	44,262	46,592	636,957	13.67	5
6	CNA Trainees	0				6
7	Licensed Therapist	1,720	1,810	44,154	24.39	7
8	Rehab/Therapy Aides	435	458	7,262	15.86	8
9	Activity Director	0				9
10	Activity Assistants	1,976	2,080	24,960	12.00	10
11	Social Service Workers	494	520	9,880	19.00	11
12	Dietician					12
13	Food Service Supervisor	1,976	2,080	37,440	18.00	13
14	Head Cook	0				14
15	Cook Helpers/Assistants	4,585	4,826	56,992	11.81	15
16	Dishwashers	494	520	5,543	10.66	16
17	Maintenance Workers	1,976	2,080	37,825	18.19	17
18	Housekeepers	7,648	8,050	65,582	8.15	18
19	Laundry	4,190	4,410	38,320	8.69	19
20	Administrator	1,976	2,080	65,000	31.25	20
21	Assistant Administrator					21
22	Other Administrative	4,684	4,930	95,979	19.47	22
23	Office Manager	0				23
24	Clerical	3,636	3,827	32,236	8.42	24
25	Vocational Instruction	0				25
26	Academic Instruction	0				26
27	Medical Director	0				27
28	Qualified MR Prof. (QMRP)	3,952	4,160	63,856	15.35	28
29	Resident Services Coordinator	0				29
30	Habilitation Aides (DD Homes)	0				30
31	Medical Records	395	416	4,576	11.00	31
32	Other Health C: Transportation	790	832	9,768	11.74	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	105,837	111,407	$ 1,824,457 *	$ 16.38	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	161	$ 7,959	1	35
36	Medical Director	Monthly	29,002	9	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	373	20,835	10a	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Psychologist	15	1,296	10a	46
47	Vision	Monthly	3,879	10	47
48					48
49	TOTAL (lines 35 - 48)	549	$ 62,971		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	4,645	$ 217,473	10	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	3,845	96,960	10	52
53	TOTAL (lines 50 - 52)	8,490	$ 314,433		53

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/04 Ending: 06/30/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Lois Kramer	Administrator		$ 65,000
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 65,000

B. Administrative - Other

Description	Amount
N/A	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
KPMG	audit fees	$ 8,703
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 8,703

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 37,432
Unemployment Compensation Insurance	9,351
FICA Taxes	139,571
Employee Health Insurance	100,446
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	40,751
Dental	9,100
Life Insurance/Disability	1,114
TOTAL (agree to Schedule V, line 22, col.8)	$ 337,765

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	40,666
Health Care Worker Background Check	
(Indicate # of checks performed)	
IHCA Dues	1,518
Misc. Dues/Subscriptions	2,224
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 44,408

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	5,385
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,385

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/04 Ending: 06/30/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Marklund Children's Home # 0011288 **Report Period Beginning:** 07/01/04 **Ending:** 06/30/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Healthcare Association - $1,518**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **26,853** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **202,255**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **Yes, Sch.8** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **Yes (NDSEC Rent)** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **15%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? Yes
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **KPMG** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

Cost Report **Marklund Children's Home** **6015796**
Seminars
FY 05

Date of Seminar	Company Providing Seminar	Persons Attending	Job Title	Cost of Seminar
8/16/2004	Illinois Healthcare Association- Annual /Conference	Randy Cooper	Administrator - MCH	$ 42.97
		Rose Cousins	RN- DON	42.98
		Natalie Rubino	QMRP	42.98
12/01/04	National Seminar Group- Mgmt Skills	Natalie Rubino	QMRP	179.00
12/03/04	EMS Nursing Education- Lab Test Seminar	Mary Chow	RN	110.00
01/27/05	Cross Country Seminar- HIPAA- Medical Records	Irene Kasnicka	RN- Quality Assurance Director	179.00
		Natalie Rubino	QMRP	179.00
02/10/05	Seminar Information Service - Time Mgmt	Rose Cousins	RN- Don	199.00
02/15/05	AMDA Registar- Symposium	Irene Kasnicka	RN- Quality Assurance Director	500.00
02/15/05	Shelly Lewis -AMDA Registar- Air Fare	Irene Kasnicka	RN- Quality Assurance Director	279.35
2/15/2005	The Institute-Seminar- Pressure Ulcers	Rose Cousins	RN- DON	104.25
		Randy Cooper	Administrator / MCH	104.25
3/23/2005	Central ILL-DDNA - Conf Developmental Disabilities	Brandy Chapman	RN	100.00
4/7/2005	Enviromental Training Consultants	Mike Ronnerberg	Maintenance	11.11
6/9/2005	Fred Pryor-Seminars	Lois Kramer	Administrator of Therapy	164.50
8/10/2004	Illinois State Council- SHRM Conference	Joan Rubino	Director of Human Resources	85.77
		Lissy Rivera	Employment & Benefit Coord.	85.77
8/16/2004	Illinois Healthcare Association- Annual /Conference	Diana Book	Director of Support Services	22.17
9/8/2004	Waubonsee Community College- Excel Class	Becky Dahm	Accounts Payable Clerk	42.76
9/15/2004	Padgett Thompson- Conference/Workshop	Sarah Jensen	Adm. Asst. / CEO Joel	79.92
		Peggy Szarynski	Adm. Asst. / H/R	79.92
9/30/2004	Voice of the Retarded - Annual Dues	Joel Rusco	President/CEO	155.38
9/30/2004	AICPA-Membership	Lisa Custardo	Executive Director	42.06
10/15/04	American Red Cross - CPR & 1st Aid Class	Alice Morgan	LPN	73.34
10/28/2004	Business 21- Phone Conference- EEOC Charges & Liabil	Joan Rubino	Director of Human Resources	24.74
		Lissy Riviera	Employment & Benefit Coord.	24.74
11/17/2004	Rockhurst Univ- Seminar- Philosophy at Work	Joan Rubino	Director of Human Resources	5.71
4/7/2005	Enviromental Training Consultants	Mike Ronnerberg	Maintenance	2.76
06/01/05	Culture Training	Lisa Custardo	Executive Director	220.14
		Joel Rusco	President/CEO	220.14
		Joan Rubino	Director of Human Resources	220.14
		Wendy Berk	Administrator	220.14
		Nancy Rodriguez	Director of Adult Services	220.14
		Terry Arya	VP of Development	220.14
		Kudus Badmus	Director of Finance	220.14
		Lois Kramer	Director of Children's Services	220.14
		Randy Cooper	Administrator	220.14
		Cindy Hilsabeck	Administrator	220.14
		Jeannine Zupo	Director of PR/Marketing	220.14
				$ 5,384.97

Type	Manufacturer	Model	Qty
Copier	Minolta	DI 550	1
Fax	Minolta	2600	1
Fax	Minolta	1600	1